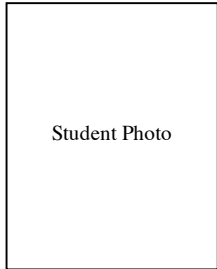


HAWTHORN SCHOOL DISTRICT #73
Vernon Hills, IL 60061
SEIZURE MANAGEMENT PLAN
(To be completed by parent - please use black ink)



School Year _____ to _____

Student _____ Grade _____ Teacher _____

Name/Daytime phone: Mother _____ / _____ Father _____ / _____

Physician _____ Address _____ Phone _____

TYPE(S) OF SEIZURE: _____

DESCRIPTION OF TYPICAL SEIZURE:

- Body involvement: _____
- Average duration: _____
- Frequency (daily/weekly/other): _____
- Usual times of day: _____
- Behavior/warning prior to seizure: _____
- Student response to seizure: _____

CARE NEEDED DURING SEIZURE: _____

CARE NEEDED AFTER SEIZURE:

- Rest for approximately _____ minutes in nurse's office
- Other _____

DAILY MEDICATION

MEDICATION	DOSE/ROUTE	TIME	POSSIBLE SIDE EFFECT

(OVER)

PHYSICAL EDUCATION/TEAM SPORTS/RECESS:

- Full participation, no limitations
- Participation with the following modifications _____

EMERGENCY INTERVENTION:

- If seizure lasts longer than _____ minutes, then _____
- If _____ or more seizures occur in a row, then _____
- If seizure occurs on the bus, then _____
- Other _____

INSTRUCTIONS:

- Seizure Observation Record (see attached sample) to be completed by staff during school and shared with parents on a _____ (weekly/monthly/other) interval. Best method of exchange of information:

- If school is unable to reach parents in an emergency, permission is granted to contact physician, listed above.

Additional comments: _____

- I/we agree to release this information to the following staff, as appropriate, with the expectation that confidentiality will be respected at all times:

- | | |
|--|--|
| <input type="checkbox"/> Teachers | <input type="checkbox"/> After school caregivers/coaches |
| <input type="checkbox"/> Substitute teacher(s) | <input type="checkbox"/> Bus personnel |
| <input type="checkbox"/> Recess staff | <input type="checkbox"/> Cafeteria/kitchen personnel |
| <input type="checkbox"/> Other _____ | |

Parent Signature

Date